nevada orthopedics

Patient Registration Form

Patient Information

Last Name: _____ First Name: _____ MI:_____
Address: _____
City: _____ State: _____ Zip Code: _____
Home: _____ May we leave a message? ☐ Yes ☐ No
Work: _____ May we leave a message? ☐ Yes ☐ No
Cell: _____ May we leave a message? ☐ Yes ☐ No
Email address: _____
Sex: ☐Male ☐Female Other DOB: _____ SSN: _____
Race: _____ Language Preference if not English: _____
Ethnicity: ☐Hispanic ☐Latino ☐ Not Hispanic or Latino
Marital Status: ☐Single ☐Married ☐Divorced ☐Widow ☐Significant other
Preferred Hospital: _____
Preferred Lab: _____
Pharmacy: _____ Location: _____
Employment Status: ☐Employed ☐Unemployed ☐Self Employed ☐Retired ☐ Disabled
Employer: _____

Responsible Party If Patient Is A Minor

Last Name: _____ First Name: _____ MI: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Telephone: _____ Relationship: _____
SSN: _____ DOB: _____

Insurance Information

Primary Insurance Carrier: _____
ID Number: _____ Group Number: _____
Subscribers Name: _____ DOB: _____
SSN: _____ Employer: _____
Secondary Insurance Carrier: _____
ID Number: _____ Group Number: _____
Subscribers Name: _____ DOB: _____
SSN: _____ Employer: _____

Miscellaneous

Emergency Contact Name and Number: _____
Referring Doctor: _____ Primary Care Physician: _____
HIPAA Contact (Any person or persons we can talk to in regards to your healthcare): _____

Assignment and Release

I, the undersigned, have insurance coverage listed above and authorize benefits be paid directly to Nevada Orthopedics. I understand that I am financially responsible for payment of all services whether or not paid by my insurance. I hereby authorize Nevada Orthopedics to release all information necessary to secure the payment of benefits.

_____ _____
Signature of Patient/ Guardian Date

I have received a copy of this office's **Notice of Privacy Policy.**

_____ _____
Signature of Patient/ Guardian Date

www.nvorthopedics.com

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